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§15–103.

(a) (1) The Secretary shall administer the Maryland Medical Assistance Program.

(2) The Program:

(i) Subject to the limitations of the State budget, shall provide medical and other health care services for indigent individuals or medically indigent individuals or both;

(ii) Shall provide, subject to the limitations of the State budget, comprehensive medical, dental, and other health care services for all eligible pregnant women whose family income is at or below 250 percent of the poverty level for the duration of the pregnancy and for 1 year immediately following the end of the woman's pregnancy, as permitted by the federal law;

(iii) Shall provide, subject to the limitations of the State budget, comprehensive medical and other health care services for all eligible children currently under the age of 1 whose family income falls below 185 percent of the poverty level, as permitted by federal law;

(iv) Beginning on January 1, 2012, shall provide, subject to the limitations of the State budget, family planning services to all women whose family income is at or below 200 percent of the poverty level, as permitted by federal law;

(v) Shall provide, subject to the limitations of the State budget, comprehensive medical and other health care services for all children from the age of 1 year up through and including the age of 5 years whose family income falls below 133 percent of the poverty level, as permitted by the federal law;

(vi) Beginning on January 1, 2014, shall provide, subject to the limitations of the State budget, comprehensive medical care and other health care services for all children who are at least 6 years of age but are under 19 years of age whose family income falls below 133 percent of the poverty level, as permitted by federal law;

(vii) Shall provide, subject to the limitations of the State budget, comprehensive medical care and other health care services for all legal immigrants who meet Program eligibility standards and who arrived in the United States before

August 22, 1996, the effective date of the federal Personal Responsibility and Work Opportunity Reconciliation Act, as permitted by federal law;

(viii) Shall provide, subject to the limitations of the State budget and any other requirements imposed by the State, comprehensive medical care and other health care services for all legal immigrant children under the age of 18 years and pregnant women who meet Program eligibility standards and who arrived in the United States on or after August 22, 1996, the effective date of the federal Personal Responsibility and Work Opportunity Reconciliation Act;

(ix) Beginning on January 1, 2014, shall provide, subject to the limitations of the State budget, and as permitted by federal law, medical care and other health care services for adults whose annual household income is at or below 133 percent of the poverty level;

(x) Subject to the limitations of the State budget, and as permitted by federal law:

1. Shall provide comprehensive medical care and other health care services for former foster care adolescents who, on their 18th birthday, were in foster care under the responsibility of the State and are not otherwise eligible for Program benefits;

2. May provide comprehensive medical care and other health care services for former foster care adolescents who, on their 18th birthday, were in foster care under the responsibility of any other state or the District of Columbia; and

3. May provide comprehensive dental care for former foster care adolescents who, on their 18th birthday, were in foster care under the responsibility of the State;

(xi) May include bedside nursing care for eligible Program recipients;

(xii) Shall provide services in accordance with funding restrictions included in the annual State budget bill;

(xiii) Beginning on January 1, 2019, may provide, subject to the limitations of the State budget, and as permitted by federal law, dental services for adults whose annual household income is at or below 133 percent of the poverty level;

(xiv) Shall provide, subject to the limitations of the State budget, medically appropriate drugs that are approved by the United States Food and Drug

Administration for the treatment of hepatitis C, regardless of the fibrosis score, and that are determined to be medically necessary;

(xv) Shall provide, subject to the limitations of the State budget, health care services appropriately delivered through telehealth to a patient in accordance with § 15–141.2 of this subtitle;

(xvi) Beginning on January 1, 2021, shall provide, subject to the limitations of the State budget and § 15–855(b)(2) of the Insurance Article, and as permitted by federal law, services for pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute onset neuropsychiatric syndrome, including the use of intravenous immunoglobulin therapy, for eligible Program recipients, if pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute onset neuropsychiatric syndrome are coded for billing and diagnosis purposes in accordance with § 15–855(d) of the Insurance Article; and

(xvii) Beginning on January 1, 2022, may not include, subject to federal approval and limitations of the State budget, a frequency limitation on covered dental prophylaxis care or oral health exams that requires the dental prophylaxis care or oral health exams to be provided at an interval greater than 120 days within a plan year.

(3) Subject to restrictions in federal law or waivers, the Department may:

(i) Impose cost–sharing on Program recipients; and

(ii) For adults who do not meet requirements for a federal category of eligibility for Medicaid:

1. Cap enrollment; and

2. Limit the benefit package.

(4) Subject to the limitations of the State budget, the Department shall implement the provisions of Title II of the federal Patient Protection and Affordable Care Act, as amended by the federal Health Care and Education Reconciliation Act of 2010, to include:

(i) Parents and caretaker relatives who have a dependent child living in the parents' or caretaker relatives' home; and

(ii) Adults who do not meet requirements, such as age, disability, or parent or caretaker relative of a dependent child, for a federal category of eligibility for Medicaid and who are not enrolled in the federal Medicare program, as enacted by Title XVII of the Social Security Act.

(b) (1) As permitted by federal law or waiver, the Secretary may establish a program under which Program recipients are required to enroll in managed care organizations.

(2) (i) The benefits required by the program developed under paragraph (1) of this subsection shall be adopted by regulation and shall be equivalent to the benefit level required by the Maryland Medical Assistance Program on January 1, 1996.

(ii) Subject to the limitations of the State budget and as permitted by federal law or waiver, the Department shall provide reimbursement for medically necessary and appropriate inpatient, intermediate care, and halfway house substance abuse treatment services for substance abusing enrollees 21 years of age or older who are recipients of temporary cash assistance under the Family Investment Program.

(iii) Each managed care organization participating in the program developed under paragraph (1) of this subsection shall provide or arrange for the provision of the benefits described in subparagraph (ii) of this paragraph.

(iv) Nothing in this paragraph may be construed to prohibit a managed care organization from offering additional benefits, if the managed care organization is not receiving capitation payments based on the provision of the additional benefits.

(v) Notwithstanding subparagraph (i) of this paragraph, the benefits required by the program developed under paragraph (1) of this subsection shall include dental services for pregnant women.

(3) Subject to the limitations of the State budget and as permitted by federal law or waiver, the program developed under paragraph (1) of this subsection and the program developed under § 15–301 of this title may provide guaranteed eligibility for each enrollee for up to 6 months, unless an enrollee obtains health insurance through another source.

(4) (i) The Secretary may exclude specific populations or services from the program developed under paragraph (1) of this subsection.

(ii) For any populations or services excluded under this paragraph, the Secretary may authorize a managed care organization, to provide the services or provide for the population, including authorization of a separate dental managed care organization or a managed care organization to provide services to Program recipients with special needs.

(5) (i) Except for a service excluded by the Secretary under paragraph (4) of this subsection, each managed care organization shall provide all the benefits required by regulations adopted under paragraph (2) of this subsection.

(ii) For a population or service excluded by the Secretary under paragraph (4) of this subsection, the Secretary may authorize a managed care organization to provide only for that population or provide only that service.

(iii) A managed care organization may subcontract specified required services to a health care provider that is licensed or authorized to provide those services.

(6) Except for the Program of All–inclusive Care for the Elderly ("PACE") Program, the Secretary may not include the long–term care population or long–term care services in the program developed under paragraph (1) of this subsection.

(7) The program developed under paragraph (1) of this subsection shall ensure that enrollees have access to a pharmacy that:

(i) Is licensed in the State; and

(ii) Is within a reasonable distance from the enrollee's residence.

(8) For cause, the Department may disenroll enrollees from a managed care organization and enroll them in another managed care organization.

(9) Each managed care organization shall:

(i) Have a quality assurance program in effect which is subject to the approval of the Department and which, at a minimum:

1. Complies with any health care quality improvement system developed by the Centers for Medicare and Medicaid Services;

2. Complies with the quality requirements of applicable State licensure laws and regulations;

3. Complies with practice guidelines and protocols specified by the Department;

4. Provides for an enrollee grievance system, including an enrollee hotline;

5. Provides a provider grievance system;

6. Provides for enrollee and provider satisfaction surveys, to be taken at least annually;

7. Provides for a consumer advisory board to receive regular input from enrollees;

8. Provides for an annual consumer advisory board report to be submitted to the Secretary; and

9. Complies with specific quality, access, data, and performance measurements adopted by the Department for treating enrollees with special needs;

(ii) Submit to the Department:

1. Service–specific data by service type in a format to be established by the Department;

2. Utilization and outcome reports, such as the Health Plan Employer Data and Information Set (HEDIS), as directed by the Department; and

3. At least semiannually, aggregate data that includes:

A. The number of enrollees provided with substance abuse treatment services; and

B. The amount of money spent on substance abuse treatment;

(iii) Promote timely access to and continuity of health care services for enrollees;

(iv) Demonstrate organizational capacity to provide special programs, including outreach, case management, and home visiting, tailored to meet the individual needs of all enrollees;

(v) Provide assistance to enrollees in securing necessary health care services;

(vi) Provide or assure alcohol and drug abuse treatment for substance abusing pregnant women and all other enrollees of managed care organizations who require these services;

(vii) Educate enrollees on health care prevention and good health habits;

(viii) Assure necessary provider capacity in all geographic areas under contract;

(ix) Be accountable and hold its subcontractors accountable for standards established by the Department and, upon failure to meet those standards, be subject to one or more of the following penalties:

1. Fines;

2. Suspension of further enrollments;

3. Withholding of all or part of the capitation payment;

4. Termination of the contract;

5. Disqualification from future participation in the Program; and

6. Any other penalties that may be imposed by the Department;

(x) Subject to applicable federal and State law, include incentives for enrollees to comply with provisions of the managed care organization;

(xi) Provide or arrange to provide primary mental health services;

(xii) Provide or arrange to provide all Medicaid–covered services required to comply with State statutes and regulations mandating health and mental health services for children in State supervised care:

1. According to standards set by the Department; and

2. Locally, to the extent the services are available locally;

(xiii) Submit to the Department aggregate information from the quality assurance program, including complaints and resolutions from the enrollee and provider grievance systems, the enrollee hotline, and enrollee satisfaction surveys;

(xiv) Maintain as part of the enrollee's medical record the following information:

1. The basic health risk assessment conducted on enrollment;

2. Any information the managed care organization receives that results from an assessment of the enrollee conducted for the purpose of any early intervention, evaluation, planning, or case management program;

3. Information from the local department of social services regarding any other service or benefit the enrollee receives, including assistance or benefits from a program administered by the Department of Human Services under the Human Services Article; and

4. Any information the managed care organization receives from a school–based clinic, a core services agency, a local health department, or any other person that has provided health services to the enrollee;

(xv) Upon provision of information specified by the Department under paragraph (19) of this subsection, pay school–based clinics for services provided to the managed care organization's enrollees; and

(xvi) In coordination with participating dentists, enrollees, and families of enrollees, develop a process to arrange to provide dental therapeutic treatment to individuals under 21 years of age that requires:

1. A participating dentist to notify a managed care organization when an enrollee is in need of therapeutic treatment and the dentist is unable to provide the treatment;

2. A managed care organization to provide the enrollee or the family of the enrollee with a list of participating providers who offer therapeutic dental services; and

3. A managed care organization to notify the enrollee or the family of the enrollee that the managed care organization will provide further assistance if the enrollee has difficulty obtaining an appointment with a provider of therapeutic dental services.

(10) The Department shall adopt regulations that assure that managed care organizations employ appropriate personnel to:

(i) Assure that individuals with special needs obtain needed services; and

(ii) Coordinate those services.

(11) (i) A managed care organization shall reimburse a hospital emergency facility and provider for:

1. Health care services that meet the definition of emergency services in § 19–701 of this article;

2. Medical screening services rendered to meet the requirements of the federal Emergency Medical Treatment and Active Labor Act;

3. Medically necessary services if the managed care organization authorized, referred, or otherwise allowed the enrollee to use the emergency facility and the medically necessary services are related to the condition for which the enrollee was allowed to use the emergency facility; and

4. Medically necessary services that relate to the condition presented and that are provided by the provider in the emergency facility to the enrollee if the managed care organization fails to provide 24–hour access to a physician as required by the Department.

(ii) A provider may not be required to obtain prior authorization or approval for payment from a managed care organization in order to obtain reimbursement under this paragraph.

(12) (i) Each managed care organization shall notify each enrollee when the enrollee should obtain an immunization, examination, or other wellness service.

(ii) Each managed care organization shall:

1. Maintain evidence of compliance with paragraph (9) of this subsection; and

2. Provide to the Department, upon initial application to provide health care services to enrollees and on an annual basis thereafter, evidence of compliance with paragraph (9) of this subsection, including submission of a written plan.

(iii) A managed care organization that does not comply with subparagraph (i) of this paragraph for at least 90% of its new enrollees:

1. Within 90 days of their enrollment may not receive more than 80% of its capitation payments;

2. Within 180 days of their enrollment may not receive more than 70% of its capitation payments; and

3. Within 270 days of their enrollment may not receive more than 50% of its capitation payments.

(iv) If a managed care organization does not comply with the requirements of paragraph (9) of this subsection, the Department may contract with any community–based health organization that the Department determines is willing and able to perform comprehensive outreach services to enrollees.

(v) In addition to the provisions of subparagraph (iv) of this paragraph, if a managed care organization does not comply with the requirements of paragraph (9) of this subsection or fails to provide evidence of compliance to the Department under subparagraph (ii) of this paragraph, the Department may:

1. Impose a fine on the managed care organization which shall be deposited in the HealthChoice Performance Incentive Fund established under § 15–103.3 of this subtitle;

2. Suspend further enrollment into the managed care organization;

3. Withhold all or part of the capitation rate from the managed care organization;

4. Terminate the provider agreement; or

5. Disqualify the managed care organization from future participation in the Maryland Medicaid Managed Care Program.

(13) The Department shall:

(i) Establish and maintain an ombudsman program and a locally accessible enrollee hotline;

(ii) Perform focused medical reviews of managed care organizations that include reviews of how the managed care organizations are providing health care services to special populations;

(iii) Provide timely feedback to each managed care organization on its compliance with the Department's quality and access system;

(iv) Establish and maintain within the Department a process for handling provider complaints about managed care organizations; and

(v) Adopt regulations relating to appeals by managed care organizations of penalties imposed by the Department, including regulations providing for an appeal to the Office of Administrative Hearings.

(14) (i) Except as provided in subparagraph (iii) of this paragraph, the Department shall delegate responsibility for maintaining the ombudsman program for a county to that county's local health department on the request of the local health department.

(ii) A local health department may not subcontract the ombudsman program.

(iii) Before the Department delegates responsibility to a local health department to maintain the ombudsman program for a county, a local health department that is also a Medicaid provider must receive the approval of the Secretary and the local governing body.

(15) A managed care organization may not:

(i) Without authorization by the Department, enroll an individual who at the time is a Program recipient; or

(ii) Have face–to–face or telephone contact, or otherwise solicit with an individual who at the time is a Program recipient before the Program recipient enrolls in the managed care organization unless:

1. Authorized by the Department; or

2. The Program recipient initiates contact.

(16) (i) The Department shall be responsible for enrolling Program recipients into managed care organizations.

(ii) The Department may contract with an entity to perform the enrollment function.

(iii) The Department or its enrollment contractor shall administer a health risk assessment developed by the Department to ensure that individuals who need special or immediate health care services will receive the services on a timely basis.

(iv) The Department or its enrollment contractor:

1. May administer the health risk assessment only after the Program recipient has chosen a managed care organization; and

2. Shall forward the results of the health risk assessment to the managed care organization chosen by the Program recipient within 5 business days.

(17) For a managed care organization with which the Secretary contracts to provide services to Program recipients under this subsection, the Secretary shall establish a mechanism to initially assure that each historic provider that meets the Department's quality standards has the opportunity to continue to serve Program recipients as a subcontractor of at least one managed care organization.

(18) (i) The Department shall make capitation payments to each managed care organization as provided in this paragraph.

(ii) In consultation with the Insurance Commissioner, the Secretary shall:

1. Set capitation payments at a level that is actuarially adjusted to the benefits provided; and

2. Actuarially adjust the capitation payments to reflect the relative risk assumed by the managed care organization.

(iii) In actuarially adjusting capitation payments under subparagraph (ii)2 of this paragraph, the Secretary, in consultation with the Insurance Commissioner, shall take into account, to the extent allowed under federal law, the expenses incurred by the managed care organization applicable to the business of providing care to enrolled individuals.

(19) (i) School–based clinics and managed care organizations shall collaborate to provide continuity of care to enrollees.

(ii) School–based clinics shall be defined by the Department in consultation with the State Department of Education.

(iii) Each managed care organization shall require a school–based clinic to provide to the managed care organization certain information, as specified by the Department, about an encounter with an enrollee of the managed care organization prior to paying the school–based clinic.

(iv) Upon receipt of information specified by the Department, the managed care organization shall pay, at Medicaid–established rates, school–based clinics for covered services provided to enrollees of the managed care organization.

(v) The Department shall work with managed care organizations and school–based clinics to develop collaboration standards, guidelines, and a process to assure that the services provided are covered and medically appropriate and that the process provides for timely notification among the parties.

(vi) Each managed care organization shall maintain records of all health care services:

1. Provided to its enrollees by school–based clinics; and

2. For which the managed care organization has been billed.

(20) The Department shall establish standards for the timely delivery of services to enrollees.

(21) (i) The Department shall establish a delivery system for specialty mental health services for enrollees of managed care organizations.

(ii) The Behavioral Health Administration shall:

1. Design and monitor the delivery system;

2. Establish performance standards for providers in the delivery system; and

3. Establish procedures to ensure appropriate and timely referrals from managed care organizations to the delivery system that include:

A. Specification of the diagnoses and conditions eligible for referral to the delivery system;

B. Training and clinical guidance in appropriate use of the delivery system for managed care organization primary care providers;

C. Preauthorization by the utilization review agent of the delivery system; and

D. Penalties for a pattern of improper referrals.

(iii) The Department shall collaborate with managed care organizations to develop standards and guidelines for the provision of specialty mental health services.

(iv) The delivery system shall:

1. Provide all specialty mental health services needed by enrollees;

2. For enrollees who are dually diagnosed, coordinate the provision of substance abuse services provided by the managed care organizations of the enrollees;

3. Consist of a network of qualified mental health professionals from all core disciplines;

4. Include linkages with other public service systems; and

5. Comply with quality assurance, enrollee input, data collection, and other requirements specified by the Department in regulation.

(v) The Department may contract with a managed care organization for delivery of specialty mental health services if the managed care organization meets the performance standards adopted by the Department in regulations.

(vi) The provisions of § 15–1005 of the Insurance Article apply to the delivery system for specialty mental health services established under this paragraph and administered by an administrative services organization.

(22) The Department shall include a definition of medical necessity in its quality and access standards.

(23) (i) The Department shall adopt regulations relating to enrollment, disenrollment, and enrollee appeals.

(ii) Program recipients shall have the right to choose:

1. The managed care organization with which they are enrolled; and

2. The primary care provider to whom they are assigned within the managed care organization.

(iii) If a recipient is disenrolled and reenrolls within 120 days of the recipient's disenrollment, the Department shall:

1. Assign the recipient to the managed care organization in which the recipient previously was enrolled; and

2. Require the managed care organization to assign the recipient to the primary care provider of record at the time of the recipient's disenrollment.

(iv) Whenever a recipient has to select a new managed care organization because the recipient's managed care organization has departed from the HealthChoice Program, the departing managed care organization:

1. Shall provide a written notice to the recipient 60 days before departing from the Program;

2. Shall include in the notice the name and provider number of the primary care provider assigned to the recipient and the telephone number of the enrollment broker; and

3. Within 30 days after departing from the Program, shall provide the Department with a list of enrollees and the name of each enrollee's primary care provider.

(v) On receiving the list provided by the managed care organization, the Department shall provide the list to:

1. The enrollment broker to assist and provide outreach to recipients in selecting a managed care organization; and

2. The remaining managed care organizations for the purpose of linking recipients with a primary care provider in accordance with federal law and regulation.

(vi) Subject to subsection (f)(4) and (5) of this section, an enrollee may disenroll from a managed care organization:

1. Without cause in the month following the anniversary date of the enrollee's enrollment; and

2. For cause, at any time as determined by the Secretary.

(24) The Department or its subcontractor, to the extent feasible in its marketing or enrollment programs, shall hire individuals receiving assistance under the program of Aid to Families with Dependent Children established under Title IV, Part A, of the Social Security Act, or the successor to the program.

(25) The Department shall disenroll an enrollee who is a child in State–supervised care if the child is transferred to an area outside of the territory of the managed care organization.

(26) The Secretary shall adopt regulations to implement the provisions of this section.

(27) (i) 1. The Department shall establish the Maryland Medicaid Advisory Committee, composed of no more than 25 members.

2. The majority of the members of the Committee shall be enrollees or enrollee advocates.

3. At least five members of the Committee shall be enrollees representative of the entire Medicaid population.

(ii) The Committee members shall include:

1. At least five current or former enrollees or the parents or guardians of current or former enrollees;

2. Providers who are familiar with the medical needs of low–income population groups, including board–certified physicians;

3. Hospital representatives;

4. At least five but not more than 10 advocates for the Medicaid population, including representatives of special needs populations, such as:

A. Children with special needs;

B. Individuals with physical disabilities;

C. Individuals with developmental disabilities;

D. Individuals with mental illness;

E. Individuals with brain injuries;

F. Medicaid and Medicare dual eligibles;

G. Individuals who are homeless or have experienced homelessness;

H. Individuals enrolled in home– and community–based services waivers;

I. Elderly individuals;

J. Low–income individuals and individuals receiving benefits through the Temporary Assistance for Needy Families Program; and

K. Individuals receiving substance abuse treatment services;

5. Two members of the Finance Committee of the Senate of Maryland, appointed by the President of the Senate; and

6. Three members of the Maryland House of Delegates, appointed by the Speaker of the House.

(iii) A designee of each of the following shall serve as an ex–officio member of the Committee:

1. The Secretary of Human Services;

2. The Executive Director of the Maryland Health Care Commission; and

3. The Maryland Association of County Health Officers.

(iv) In addition to any duties imposed by federal law and regulation, the Committee shall:

1. Advise the Secretary on the implementation, operation, and evaluation of managed care programs under this section;

2. Review and make recommendations on the regulations developed to implement managed care programs under this section;

3. Review and make recommendations on the standards used in contracts between the Department and managed care organizations;

4. Review and make recommendations on the Department's oversight of quality assurance standards;

5. Review data collected by the Department from managed care organizations participating in the Program and data collected by the Maryland Health Care Commission;

6. Promote the dissemination of managed care organization performance information, including loss ratios, to enrollees in a manner that facilitates quality comparisons and uses layman's language;

7. Assist the Department in evaluating the enrollment process; and

8. Review reports of the ombudsmen.

(v) Except as specified in subparagraphs (ii) and (iii) of this paragraph, the members of the Maryland Medicaid Advisory Committee shall be appointed by the Secretary and serve for a 4–year term.

(vi) In making appointments to the Committee, the Secretary shall provide for continuity and rotation.

(vii) In appointing consumer members to the Committee, the Secretary shall seek recommendations from:

1. The State Protection and Advocacy System Organization;

2. The Statewide Independent Living Council;

3. The Developmental Disabilities Council;

4. The Department of Disabilities;

5. The Department of Aging;

6. Consumer advocacy organizations; and

7. The public.

(viii) The Secretary shall appoint the chair of the Committee.

(ix) The Secretary shall appoint nonvoting members from managed care organizations who may participate in Committee meetings, unless the Committee meets in closed session as provided in § 3–305 of the General Provisions Article.

(x) The Department shall provide staff for the Committee.

(xi) The Committee shall determine the times and places of its meetings.

(xii) 1. The chair of the Committee and the staff for the Committee shall provide the agenda, minutes, and any written materials to be presented or discussed at a meeting to the members of the Committee at least 5 days prior to the meeting.

2. The agenda, minutes, and written materials shall be provided to members of the Committee in a manner and format that reasonably accommodates the specific needs of the member.

(xiii) 1. Except as provided in subsubparagraph 2 of this subparagraph, a member of the Committee:

A. May not receive compensation; but

B. Is entitled to reimbursement for expenses under the Standard State Travel Regulations, as provided in the State budget.

2. A member of the Committee who is an enrollee is entitled to reimbursement for:

A. Expenses for personal and dependent care incurred during the meeting and during travel time to and from the meeting;

B. Expenses for cognitive supports related to the meeting; and

C. Appropriate transportation to and from the meeting.

3. On request, the Department shall provide for a dedicated Department staff person:

A. To review meeting materials with enrollee members in advance of a meeting by telephone or in person; and

B. To provide referrals to advocacy organizations.

(28) (i) The Department shall ensure that payments for services provided by a hospital located in a contiguous state or in the District of Columbia to an enrollee under the Program shall be reduced by 20% if the hospital fails to submit discharge data on all Maryland patients receiving care in the hospital to the Health Services Cost Review Commission in a form and manner the Commission specifies.

(ii) Subparagraph (i) of this paragraph does not apply to a hospital that presently provides discharge data to the public in a form the Health Services Cost Review Commission determines is satisfactory.

(29) A managed care organization shall provide coverage for hearing loss screenings of newborns provided by a hospital before discharge.

(30) (i) The Department shall provide enrollees and health care providers with an accurate directory or other listing of all available providers:

1. In written form, made available upon request; and

2. On an Internet database.

(ii) The Department shall update the Internet database at least every 30 days.

(iii) The written directory shall include a conspicuous reference to the Internet database.

(c) (1) (i) In this subsection the following words have the meanings indicated.

(ii) "Certified nurse practitioner" means a registered nurse who is licensed in this State, has completed a nurse practitioner program approved by the State Board of Nursing, and has passed an examination approved by that Board.

(iii) "Nurse anesthetist" means a registered nurse who is:

1. Certified under the Health Occupations Article to practice nurse anesthesia; and

2. Certified by the Council on Certification or the Council on Recertification of Nurse Anesthetists.

(iv) "Nurse midwife" means a registered nurse who is licensed in this State and has been certified by the American College of Nurse–Midwives as a nurse midwife.

(v) "Optometrist" has the meaning stated in § 11–101 of the Health Occupations Article.

(2) The Secretary may contract for the provision of care under the Program to eligible Program recipients.

(3) The Secretary may contract with insurance companies or nonprofit health service plans or with individuals, associations, partnerships, incorporated or unincorporated groups of physicians, chiropractors, dentists, podiatrists, optometrists, pharmacists, hospitals, nursing homes, nurses, including nurse anesthetists, nurse midwives and certified nurse practitioners, opticians, and other health practitioners who are licensed or certified in this State and perform services on the prescription or referral of a physician.

(4) For the purposes of this section, the nurse midwife need not be under the supervision of a physician.

(5) Except as otherwise provided by law, a contract that the Secretary makes under this subsection shall continue unless terminated under the terms of the contract by the Program or by the provider.

(d) As permitted by federal law or waiver, the Secretary may administer the Medicare Option Prescription Drug Program, established under § 15–124.3 of this subtitle, as part of the Maryland Medical Assistance Program.

(e) By regulation, the Department shall adopt a methodology to ensure that federally qualified health centers are paid reasonable cost–based reimbursement that is consistent with federal law.

(f) (1) The Department shall establish mechanisms for:

(i) Identifying a Program recipient's primary care provider at the time of enrollment into a managed care program; and

(ii) Maintaining continuity of care with the primary care provider if:

1. The provider has a contract with a managed care organization or a contracted medical group of a managed care organization to provide primary care services; and

2. The recipient desires to continue care with the provider.

(2) If a Program recipient enrolls in a managed care organization and requests assignment to a particular primary care provider who has a contract with the managed care organization or a contracted group of the managed care organization, the managed care organization shall assign the recipient to the primary care provider.

(3) A Program recipient may request a change of primary care providers within the same managed care organization at any time and, if the primary care provider has a contract with the managed care organization or a contracted group of the managed care organization, the managed care organization shall honor the request.

(4) In accordance with the federal Health Care Financing Administration's guidelines, a Program recipient may elect to disenroll from a managed care organization if the managed care organization terminates its contract with the Department.

(5) A Program recipient may disenroll from a managed care organization to maintain continuity of care with a primary care provider if:

(i) The contract between the primary care provider and the managed care organization or contracted group of the managed care organization terminates because:

1. The managed care organization or contracted group of the managed care organization terminates the provider's contract for a reason other than quality of care or the provider's failure to comply with contractual requirements related to quality assurance activities;

2. A. The managed care organization or contracted group of the managed care organization reduces the primary care provider's capitated or applicable fee for services rates;

B. The reduction in rates is greater than the actual change in rates or capitation paid to the managed care organization by the Department; and

C. The provider and the managed care organization or contracted group of the managed care organization are unable to negotiate a mutually acceptable rate; or

3. The provider contract between the provider and the managed care organization is terminated because the managed care organization is acquired by another entity; and

(ii) 1. The Program recipient desires to continue to receive care from the primary care provider;

2. The provider contracts with at least one other managed care organization or contracted group of a managed care organization; and

3. The enrollee notifies the Department or the Department's designee of the enrollee's intention within 90 days after the contract termination.

(6) The Department shall provide timely notification to the affected managed care organization of an enrollee's intention to disenroll under the provisions of paragraph (5) of this subsection.

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